



Competition in the Dutch health insurance market

Interim report

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Monitor Financial Sector
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Please note that, although every effort has been made to ensure this translation is accurate and consistent, it is for informational purposes only. In case of any dispute or inconsistencies, the Dutch version is authentic.



About the Monitor Financial Sector

This study has been conducted by the Monitor Financial Sector (MFS). The MFS is part of the Netherlands Authority for Consumers and Markets (ACM). The economists of the MFS conduct studies in the Dutch financial sector into the degree and development of competition. They can be reached by email at MFS@acm.nl



Executive summary

Since the Dutch Health Insurance Act (Zvw) came into force in 2006, the Dutch health care market is regulated by the government. One of the key objectives of the Zvw is to make health care more efficient by introducing more competitive incentives. At the heart of the Dutch health care system is the central role of health insurers. Since health insurers need to compete for customers, they are stimulated to become more efficient themselves, and to procure efficient health care services of high quality. Increased competition among health insurers thus also increases their efficiency and quality. Compared with other markets, the health insurance market is heavily regulated. Laws and regulations, which often are in place for valid reasons, restrict what health insurers can do and thus also their options to compete.

The Netherlands Authority for Consumers and Markets (ACM) has launched a study with the objective of gaining more insight into the functioning of the health insurance market, and, where possible, to come up with recommendations on how to strengthen competition. This report presents the results of the first analysis. Based on this analysis, relevant topics for the follow-up study have been identified. The objective of the follow-up study is to make concrete recommendations on how to strengthen competition in the health insurance market.

Health insurers have opportunities for competing with one another, but currently fail to take sufficient advantage of them

Commissioned by ACM, Gupta Strategists (Gupta) has identified what options health insurers have to distinguish themselves from each other. It turns out that there are many laws and regulations that apply to the health insurance market, limiting the health insurers' ability to differentiate. With regard to the basic health insurance, these include the statutory obligation to accept everyone, the risk settlement system, the 'duty of care' (in Dutch: zorgplicht), solvency requirements, and rules about the contents of the basic health insurance package. With regard to the supplemental health insurances, the various laws and regulations hardly limit health insurers in their ability to set themselves apart. However, political and public pressure on health insurers more and more limits their ability to distinguish themselves. Questions can be raised about whether or not such restrictions eventually lead to the best results.

However, Gupta also found that the remaining opportunities for differentiation and competition within the current legal and statutory frameworks are not fully taken advantage of at the moment. Health insurers thus appear not to use opportunities for introducing distinctive products that have added value for certain groups of insured without undermining public interests.

It is not self-evident that competition in the Dutch health insurance market is effective

Based on public data, a first analysis by ACM reveals that it is not self-evident that competition is effective. For example, market shares of health insurers, corrected for mergers and acquisitions, are not very dynamic, and this situation has not yet been shaken up by the entry of new health insurers. Measured in terms of the number of policies in the market, product differentiation is considerable. In this context, however, the question remains whether this differentiation is based on objective features



such as improved service or higher health care quality, or that, in part because of increasing advertising expenditures, it leads to so-called 'obfuscation.' Consumers are less able to choose the insurance policy that best meets their needs. This could be an explanation for the observed price differences in basic health insurances, but it does not necessarily need to be one if differences in quality exist accordingly. At the moment, that is still unclear.

The high number of different insurance policies can also lead to inertia among consumers, making them reluctant to switch. Although switching rates have increased over the past few years, a large share of consumers (almost 70 percent) have never switched providers since 2006. This may be connected to the distrust that consumers have of health insurers. The divide between switchers and non-switchers can also lead to price discrimination between these two groups. As a result, consumers that switch pay lower premiums than consumers who do not switch.

ACM's follow-up study

Gupta shows that the health insurers' ability to differentiate is restricted but also not fully utilized. A first analysis by ACM similarly does not directly indicate the existence of effective competition. Three hypotheses have therefore been formulated for the follow-up study. These hypotheses tie in with the most important insights that have been obtained from the study so far. This follow-up study will be conducted in cooperation with the Netherlands Healthcare Authority (Nederlandse Zorgautoriteit, NZa). The goal is to come up with specific recommendations with regard to the three hypotheses below.

Hypothesis 1: Large health insurers have insufficient incentives to set themselves apart, and thus to attract customers

Gupta (2015) shows that laws and regulations restrict what health insurers can do. Gupta also observes that health insurers are reluctant to differentiate themselves as a result of strong political and public pressure. Despite these restrictions there are still opportunities for differentiation, but Gupta argues that these opportunities are currently not taken full advantage of. With regard to health care procurement, for example, Gupta argues that health insurers could separate themselves more by procuring more selectively. One possible explanation is that health insurers do not have the incentives to distinguish themselves, and thus to gain more market share. Gupta has observed that health insurers primarily aim for consolidating market share, and not necessarily for increasing market share. The relative stability (apart from mergers and acquisitions) of the individual market shares of health insurers is in line with that observation. With a strategy of market share consolidation, health insurers have few incentives to differentiate from their competitors in order to gain market share. As a result thereof, certain products that have added value for consumers may not get off the ground. That is why ACM and NZa will examine in greater detail as to why health insurers do not take advantage of the opportunities (or why they are not incentivized to do so), and whether this has harmful effects on consumers.

Hypothesis 2: Unnecessarily high barriers to entry and expansion in the health insurance market limit the competitive pressure exerted by potential entrants and smaller health insurers

No has been no entry in Dutch health insurance market since 2006, and the growth (in absolute terms) of the smaller health insurers is very limited. Both the NZa and Gupta establish that new



health insurers must overcome different hurdles if they wish to enter the Dutch health insurance market. Such hurdles include (i) the license application process of the Dutch Central Bank (DNB), (ii) the complexity of and high risks in the market, (iii) the complexity and uncertainty in laws and regulations, and (iv) the solvency requirements. These last two factors could, next to market entry, also curb the growth of the smaller health insurers (predominantly the smaller ones). Barriers to entry and expansion result in less competitive pressure from entrants (potential or actual) and smaller health insurers, and thus has a negative effect on competition. ACM will examine whether certain barriers are unnecessarily high, and, where possible, will give recommendations on lowering certain barriers.

Hypothesis 3: Limited transparency and unnecessary complexity of the product range limit the competitive pressure that consumers can exert on health insurers

Despite the trend of the switching rate increasing every year since 2006, approximately 70 percent of the consumers have never switched providers. In addition, health insurers spend more and more money on advertising and customer recruitment, and the number of health insurance policies have increased considerably since 2006. In and of themselves, these facts are not a cause for concern. Advertisement expenditures can increase transparency in the market, and reduce the search costs in the market. Having a considerable number of policies may be a sign of increased product differentiation, which is a positive thing if these are products that meet the needs of various customer groups. However, it is also possible that an increase in the number of policies and in advertising expenditures lead to non-transparency and to the perception of product differentiation even though there are no objective product differences to base that perception on. Harm is inflicted if consumers are unnecessarily faced with an opaque and complicated range of products. It restricts the disciplining effect that consumers who actively choose their provider can exert, and, as a result, competition between health insurers decreases.

This year ACM will examine these three hypotheses further. Input from market participants is welcome, and, in that context, ACM will actively reach out to various stakeholders. Eventually, ACM wishes to come up with concrete recommendations that have a positive effect on competition in the health insurance market without harming other public interests.



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1 Introduction

In the Netherlands, health insurance is accessible to everyone: the rich and the poor, the sick and the healthy. At the same time however, this system of universal health care is a considerable cost item for Dutch society. Over the past few years, more than EUR 40 billion per year was spent on the basic health insurance.¹ With regard to the supplemental health insurance, health insurers earned an additional EUR 4.4 billion for 2014 alone.² Control of health care costs is therefore of importance. This was one of the reasons behind the introduction of a regulated market system in 2006 when the Dutch Health Insurance Act (Zvw), the Care Institutions Accreditation Act, and the Health-care Market Regulation Act were passed.³ With this system, the government seeks to create incentives for health insurers, health care providers and patients in order to make health care more efficient.⁴

Since 2006, every Dutch citizen age 18 or over is required to take out health insurance (the basic health insurance), while having the opportunity to switch providers once a year. This gives

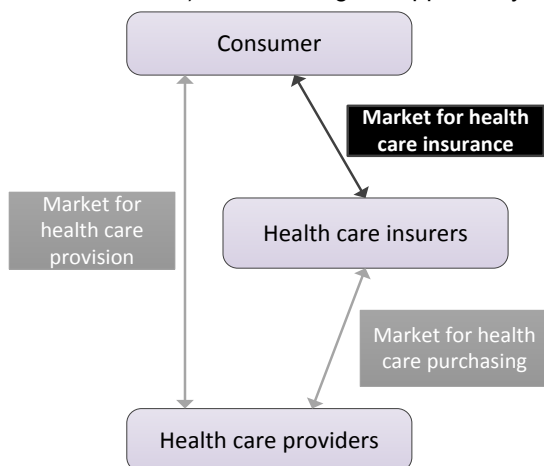


Figure 1: Overview of the Dutch health care sector. Source: Schut & Varkevisser (2009).

consumers the opportunity to express their 'dissatisfaction' with their current provider. Consumers can also switch if another insurer makes them a better offer. With competition between health insurers, vying for customers, health insurers are forced to meet the needs of their customers, meaning they need to offer insurances that give a good value for money.⁵ Next to the basic health insurance, health insurers are also able to offer supplemental health insurances. Consumers are not required to take out supplemental health insurance, and health insurers are free to create their own supplemental health insurance packages.

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Competition between health insurers does not just affect the efficiency and quality of the service of health insurers themselves. As illustrated in figure 1, health insurers have a central role in the health care market. Next to reimbursing health care costs, health insurers also procure health care from health care providers on behalf of the insured.

¹ This is the total of directly paid premiums by consumers (nominal premiums), out-of-pocket expenses (deductibles), the income-based contribution, and the national contribution for children. Source: Minister of Health (2015), table 15.

² NZa (2015a), p. 49.

³ Since its introduction, the Zvw has undergone a lot of changes. One such example is the abolition (partial and full) of different ex-post compensations since 2012. As a result, health insurers have borne more and more risk.

⁴ Schut and Varkevisser (2009), p. 251.

⁵ Explanatory Memorandum to the Zvw, p. 2.



Competition thus not only forces health insurers to become more efficient themselves, but it also forces them to procure health care more efficiently.⁶ Increased competition between health insurers therefore also increases the efficiency and quality of the health care providers.

With the introduction of the Zvw, the health care market was not turned into a full-fledged free-market system. In addition to cost control and health care efficiency, solidarity and accessibility were other important principles in the introduction of the Zvw. In a free-market system, these would be put at risk.⁷ That is why competition between health insurers takes place within a regulated framework. For example, insurers are required to accept everyone for the basic health insurance, and they are not allowed to differentiate prices. In addition to these requirements, many other laws and regulations apply. This has consequences for the extent to which health insurers compete (or are able to compete) with each other.

The importance of competition in the health insurance market

Because of the major interests (also in financial terms) that are at stake with health care, and because of the central role that health insurers play in that industry, it is important that the health insurance market functions well. This is supposed to lead to high-quality health care at relatively low prices. Increased efficiency of health care providers and health insurers enhances welfare, and also helps slow down the increase of health care costs. ACM makes sure that the market functions well, for example, by reviewing mergers and acquisitions. ACM also has the instrument of market studies at its disposal. With such studies, the level of competition in a market in a more general sense can be assessed.

ACM believes it is important to have a correct and up-to-date overview of competition between health insurers, as well as of the opportunities that insurers have to differentiate. Furthermore, the health insurance market has several other striking features besides its being a heavily regulated market. One other such feature is that it is a highly concentrated market with four major insurance groups. Also, no new insurer has entered the market since the introduction of the Zvw, and the majority of consumers have never switched providers. Finally, this market is characterized by information asymmetry between health insurers, consumers, and health care providers. For example, an individual consumer has more insight into its own health than does their health insurer. This information asymmetry may affect competition.

Structure of ACM's study

Because of the importance of having competition in the health insurance market, and the lack of clear insights into the nature and extent of competition in this market, ACM's Monitor Financial Sector (MFS) launched a study into competition in this market. This study is carried out in cooperation with

⁶ Health care is efficient if public health is realized as excellently as possible given the available resources (financial or otherwise). See also CPB (2015).

⁷ Perfect competition, for example, leads to risk-based premium discrimination, and consequently to unaffordable health care for, for example, people with chronic illnesses (Schut & Varkevisser 2009, p. 252).



ACM's Health Care Taskforce.⁸ This aim of this study is to gain more insight into the functioning of the health insurance market, and, where possible, come up with recommendations for strengthening competition. In that context, the focus is explicitly not placed on the functioning of the procurement market, but, considering the central role of health insurers in the health care market, this topic will be included, where necessary. The study has been split into several parts with this report presenting the first results.

First, ACM has commissioned research firm Gupta to carry out a study into the opportunities of health insurers to compete within the current statutory and legal framework. The study's main focus is on the health insurers' opportunities to set themselves apart and on the impediments thereto caused by laws and regulations, for example. Gupta presented its final report on December 24, 2015.⁹ In its report, Gupta gave an outline of the business model of health insurers using various elements. For these elements, Gupta subsequently examined the health insurers' opportunities and impediments to differentiation.

Next to the Gupta study, ACM also carried out its own study into the health insurance market. ACM used the Structure-Conduct-Performance model using public data and interviews with market participants. Because of data limitations, this study primarily focuses on basic health insurance. It looked into parameters that are significant to competition in order to get a picture of the level of competition in the market. This is an elaboration on previous publications of, for example, the NZa and Vektis about the health insurance market.

This report was based on the findings of Gupta's study and on the study that ACM has carried out so far. ACM's study has not been completed yet, and this report is therefore more of an exploratory nature. The goal is not, just yet, to draw any definitive conclusions or to draw up concrete recommendations in order to enhance competition in the health insurance market. This report's objective is to present the findings of Gupta's study as well as the information that ACM has collected so far. Based on this information, several hypotheses have been formulated that describe how the interplay between laws and regulations, social pressure, and the market's characteristics may have an anticompetitive effect. This year, ACM will carry out a further study to test these hypotheses, and to come up with concrete recommendations, where possible.

⁸ At this point, there is a bill that should lead to the transfer of tasks from the NZa to ACM as of 2017. In anticipation of said transfer, ACM has created the Health Care Taskforce.

⁹ The report is available here: <https://www.acm.nl/nl/publicaties/publicatie/15482/>.



2 Competition analysis

2.1 SCP model as the theoretical framework to measure competition

There are various methods to measure the level of competition in a market. In this study, ACM analyzes competition in the health insurance market using the *Structure-Conduct-Performance* (SCP) model. This model assumes causal relationships between different aspects of the market that, when combined, provide insight into the level of competition in a market. These aspects are laws and regulations, the market's structure, the conduct of market participants and consumers, and the market's performance. By collecting information about these four pillars, insight is gained into the level of competition in the health insurance market (see figure 2).

The advantage of using the SCP-model to measure the level of competition is that less quantitative data is needed than with the more advanced methods. One drawback of using this method is that competition is not measured directly, but measured indirectly using a group of parameters. These parameters do not always point in the same direction, and furthermore, the assumed causal relationship does not necessarily always exist (see also Box 1).

This chapter described the findings of the first analysis of the level of competition in the health insurance market. In the next chapter, hypotheses for further study will be formulated, on the basis of these findings.

Box 1: The SCP-model

The SCP-model is used as a theoretical framework to find a causal relationship between the structure of a market, the conduct of firms and consumers, and the market performance. One key hypothesis in the SCP-model is that, the more concentrated a market is, the less inclined firms are to compete with one another, as a result of which they are able to charge higher prices and realize higher profits (Bain, 1968).

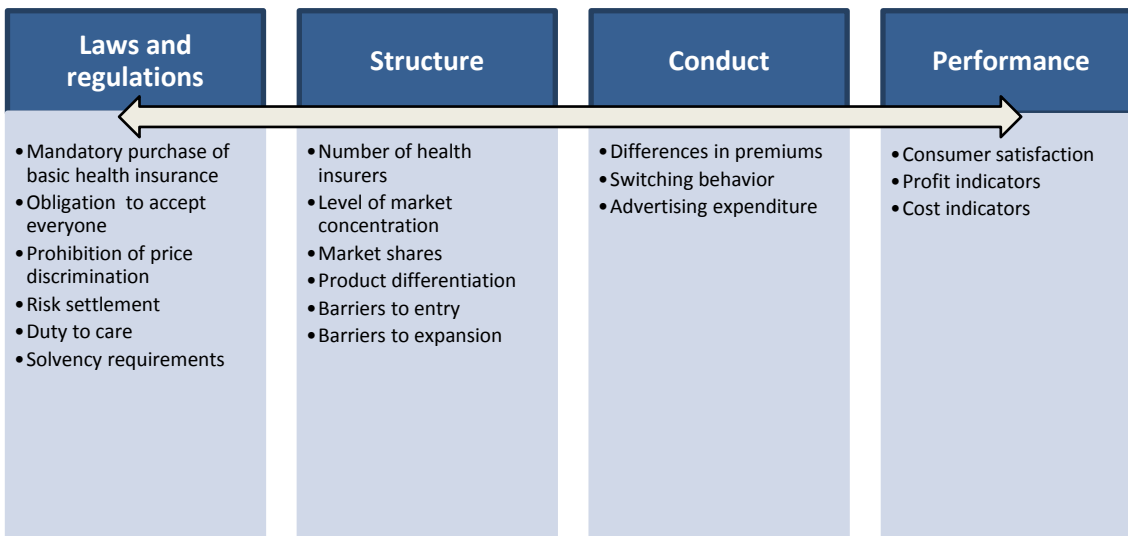
Next to the three pillars, Scherer and Ross (1990) have expanded the model by also looking at the basic conditions of the market and at the influence of regulation on the other pillars of the model. In addition, it was found that the causal relationships were not one-way relationships but actually two-way relationships. The existence of a couple of efficient market participants (performance) can, for example, lead to a concentrated market (structure). This efficiency hypothesis is, at the same time, also the most important criticism against the SCP-model, and thus warrants caution in drawing any conclusions about the level of competition on the basis of a market's characteristics.

This analysis has been carried out using public data, and it primarily concerns the basic health insurance. As approximately 84 percent of all consumers have also taken out a supplemental health insurance¹⁰, the question rises whether the basic health insurance is the right object of analysis. After all, it is conceivable that health insurers compete on the combination of the basic *and* supplemental health insurances. However, conducting such a broader analysis is currently not feasible due to a lack of sufficient information.

¹⁰ Vektis (2015), p. 18



Figure 2: overview of the SCP analysis and parameters discussed in this study



2.2 Key laws and regulations in the Dutch health insurance market

The Dutch health care system is based on a regulated-market system. In this system, the Dutch government decided to let market forces decide the optimal outcome with regard to quality and affordability of health care. At the same time, the government wishes to have a system that is accessible and based on solidarity. If the market had been given free rein, certain groups of consumers could have been denied access to the market or health could have become unaffordable to them. In order to prevent this, the government created a framework within which health insurers are able to make offers that set them apart.

Based on Gupta (2015), this section discusses what impediments health insurers encounter from laws and regulations, which hinder their ability to make distinctive propositions. Furthermore, this section also discusses other factors that can affect the health insurers' ability to differentiate as well as the competition between health insurers. An extensive analysis thereof can be found in Gupta (2015).

Limitations to differentiate caused by laws and regulations

The laws and regulations mostly concern the basic health insurance because everyone should be able to take one out.¹¹ The supplemental health insurances are subject to considerably less regulation, and are, in principle, left to market forces. In a regulated-market system, the ability of health insurers to distinguish themselves is obviously restricted.

Limitation 1: the contents of the basic health insurance package

The contents of the basic health insurance package is given, and health insurers can hardly differentiate from others with it. The basic health insurance package is a package of health care services that health insurers are statutorily required to reimburse in the basic health insurance. The scope and contents of the basic health insurance package are determined by the government, and

¹¹ Gupta (2015), p. 34



are the same for every insured individual. With regard to the basic health insurance package, health insurers are thus not able to distinguish themselves with *what* the covered health care services are, but *are* able to do so with who provides those services, how much health care is procured, the quality level thereof, and also the premiums.

Limitation 2: the risk settlement scheme

Every Dutch citizen age 18 or over is required to take out the basic health insurance. Health insurers are obligated to accept everyone for the basic health insurance, whether they be sick or healthy. This obligation to accept everyone is only tenable as long as health insurers are compensated for insured individuals with an increased risk for high costs. For that reason, the risk settlement scheme has been created. Health insurers whose customer bases have a relatively unfavorable risk profile receive relatively more compensation from the risk settlement fund so that they are compensated for this relative unfavorable risk profile. This is a complex and imperfect system that is constantly fine-tuned and adjusted to the latest risk and cost data.

The imperfections and the constant evolution of the settlement scheme pose a risk to health insurers if their customer bases differ from the average population. If they have a relatively unfavorable risk profile, health insurers then strongly rely on an equitable compensation during the risk settlement procedure. If this is not the case, or if the settlement amount changes due to adjustments to the system, risks to the revenue flows arise. Attracting a more average population for their customer bases is thus a risk-mitigating measure for health insurers, which restricts competition as it focuses on target groups.

Limitation 3: health care procurement

With respect to health care procurement, health insurers are able to distinguish themselves by negotiating a better price and/or quality, and by contracting more or fewer health care providers. Selective procurement of the better and/or more efficient health care providers may lead to lower premiums and better health care offerings, and thus also to a more distinctive proposition. However, it is not clear what the opportunities for selective procurement are.

First of all, health insurers are obligated to offer their customers high-quality care with short waiting lists and within a reasonable geographical distance. The standards for this obligation differ per health care service type, but, in any case, it does make sure that there are limits to selective procurement. Second, directing insured individuals towards certain health care providers is possible but difficult. If an insured individual goes to a non-contracted provider, the health insurer will still have to reimburse the bill (of a part thereof).¹² Furthermore, an additional financial incentive is possible such as having visits to pre-specified health care providers not count towards the insured's deductible. However, many insured use up their deductible completely, making them less sensitive to this incentive.

¹² The amount that health insurers pay non-contracted health care providers cannot be an 'obstacle' to health care consumption. Health insurers are not bound to a minimum level, but the Supreme Court of the Netherlands has ruled that a reimbursement of 50 percent or lower constitutes an obstacle.



Limitation 4: solvency requirements

According to Gupta (2015), solvency requirements, administrative hurdles, and political and public pressure make it difficult for new companies to enter the health insurance market.¹³ Solvency requirements are needed because they help insurers be able to overcome setbacks without jeopardizing their existence or the position of their customers.¹⁴ However, the solvency requirements also affect competition.¹⁵ For every new customer, the health insurer must have the required equity in advance, which means before this customer has made its first premium payment. Winning a larger market share, by charging low insurance premiums, thus carries the risk that the solvency requirements can no longer be met. This can be observed among the smaller health insurers in particular, as their current financial buffers (in absolute terms) offer little room for growth of their customer portfolio. For example, based on its capital position in late-2014, health insurer DSW was able to attract fewer than 250,000 additional customers, which is a market share of approximately 1.5 percent. According to Gupta (2015), solvency-oriented decision-making is, in general, a key priority among health insurers. They predominantly focus on maintaining market share, and not on increasing market share.¹⁶

Sub conclusion: within the legal boundaries, there is room for competition

It follows from the above that, with regard to the basic health insurance, health insurers must carry out their commercial activities within many different frameworks. This does not mean that, under the regulations, health insurers do not have any opportunities to compete with each other. Other than having to meet a certain minimum standard such as the level of quality, health insurers are completely free to make offers with more or fewer health care providers, a higher or lower quality level, higher or lower insurance premiums, shorter or longer waiting lists, etc. In addition, health insurers are able to distinguish themselves by offering different service levels or packages. Furthermore, some of the legal restrictions with regard to the basic health insurance can be circumvented with the statutory freedoms with regard to the supplemental health insurances. Mandatory co-payments can be offset in this way, for example.

The regulatory restrictions to competitive incentives often aim to safeguard solidarity or the protection of public interests.¹⁷ However, they can also have other implications. For example, the obligation to accept everyone prevents health insurers from refusing the 'sick', thereby safeguarding solidarity. At the same time, the obligation to accept everyone also calls for a risk settlement scheme. However, because of the current imperfections, health insurers are stimulated to aim for an 'average' customer base. It is thus less likely that health insurers would aim at specific target groups and, by extension, at creating prevention programs.

¹³ Gupta (2015), p. 43

¹⁴ DNB (2015)

¹⁵ Under solvency requirements, health insurers are to have sufficient equity in order to be able to meet their liabilities.

¹⁶ Gupta (2015), p. 13

¹⁷ Gupta (2015), p. 34



Limitations to differentiate caused by political and public pressure

Gupta (2015) also discusses the influence of the public and policymakers. It turns out that the political and public pressure on health insurers restrict even further the opportunities to differentiate offered by the laws and regulations.

Any restriction of the ‘freedom to choose one’s doctor’ (for example with low-cost or budget policies) is hardly accepted by society, even if health insurers claim to procure selectively health care services from the higher-quality or more efficient providers. Another aspect in this context is that insured individuals distrust health insurers when they direct them to certain health care providers. Such actions are quickly perceived as acting out of self-interest (financially or otherwise) on the health insurers’ part, whereas the insured might be even better off with the providers selected by the insurers.

Favoring specific groups is not met with great enthusiasm either. In this context, think of exclusive arrangements about evening opening hours for the clients of one specific health insurer. It appears that increased differentiation is only acceptable if it concerns health care-related services such as private rooms. This applies more and more to the supplemental health insurance too, where there is growing pressure to lower the eligibility criteria and accept all individuals. In that discussion, the benefits of having eligibility criteria for the supplemental health insurance are overlooked. If a particular insurance attracts many insured that need a lot of care, then it will obviously lead to a price increase or a reduction of the coverage.

In addition, the practice of risk selection for the supplemental and basic health insurance is met with resistance. Health insurers that target specific groups of customers are intensely scrutinized by policymakers and the public. That is why health insurers wish to avoid any semblance of risk selection, and thus target specific groups of customers as little as possible, even though, legally speaking, room to do so exists. The room to differentiate is therefore becoming even smaller for health insurers. In addition, the Dutch government in late-2014 announced a bill that prohibits any communications and activities that result in risk selection (such as marketing efforts aimed at specific groups of customers).¹⁸ Such practices are currently still legal.

Tying in with this discussion is the public and political desire to make the offerings of health insurers more transparent by reducing the number of policies. Though it can have positive effects in the form of lower search costs for the insured, it may also result in insurances that *do* meet the customers’ needs from ever reaching the market.

Finally, health insurers are expected not to make a lot of profit, even though profit-making is a core element of the free-market principle. Policymakers seek to influence this dilemma by making statements about ‘desirable’ behavior by health insurers when setting the premiums. One such example is that the Minister of Health, Welfare and Sports calls on health insurers to return any profits in the form of lower premiums, and, at the same time, the Minister incorporates such calls in

¹⁸ Act on the prohibition of vertical integration. See Minister of General Affairs (2014), p. 2.



the nominal premium calculation. Such political pressure limits the room health insurers have to set their premium independently.

Sub conclusion: statutory room to differentiate is further limited by public and political pressure

Where on the one hand, laws and regulations offer health insurers room to differentiate themselves, particularly with the supplemental health insurance, policymakers and the public, on the other hand, do not always seem to have any sympathy for activities with which health insurers are able to set themselves apart. There is little appreciation for any restriction of the freedom to choose one's doctor or to make any distinction between groups of insured. Moreover, the public has a deep distrust of health insurers. As a result thereof, health insurers are often suspected very quickly of engaging in risk-selection practices, and the insured are not easily guided in their selection of a health insurer.

Gupta (2015) therefore concludes that, when it comes to the basic health insurance, the most important options for differentiation are premiums, the freedom to choose one's doctor, the contracting rate, and the service provided to clients, as well as the marketing efforts aimed at them.¹⁹ Within the existing legislative and regulatory frameworks, health insurers definitely have a certain degree of freedom, but at the same time, that freedom is also restricted by political and public pressure. If that pressure has too restrictive an effect, it may lead to distinctive propositions not being able to get off the ground while that may be in the interest of the insured and society at large.

2.3 Structure of the Dutch health insurance market

The market structure has different elements. In this study, the structure of the health insurance market is described using the following parameters: the number of health insurers, the level of concentration, the changes in the individual market shares, the degree of product differentiation, and barriers to entry.

The number of health insurers has gone down

In general, markets with many different providers often have more competition than markets with a few providers. In 2015, 25 different firms were active in the Dutch health insurance market. These firms belonged to nine different insurance groups. Since the introduction of the Zvw, the number of health insurers and groups has gone down from 33 to 25, and from 14 to 9, respectively.²⁰

The level of concentration is rising

The level of concentration in a market is a reflection of the relative size of the different providers. A high level of concentration means that a small number of providers control a relatively large share of the market. An increase in the level of concentration can, generally speaking, have two reasons: one or more providers gain market share because they are able to operate more efficiently, or providers gain market share through mergers and acquisitions. A high level of concentration in a market is a first indication of possibly reduced competitiveness of that market.²¹

¹⁹ Gupta (2015), p. 44

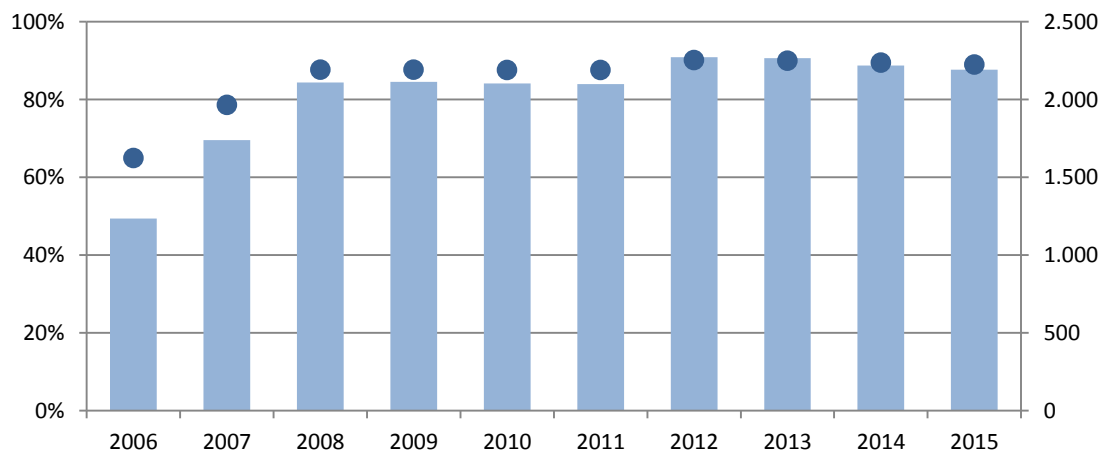
²⁰ NZa (2006), p. 5. and Vektis (2015), p. 5

²¹ For more information, see Carlton & Perloff (2005) and Bishop & Walker (2010).



There are two well-known benchmarks for the level of concentration. The C4-ratio is the combined market share of the four largest providers. The Herfindahl-Hirschman Index (HHI) is the sum of the squares of the market shares of all providers. Based on the available data, the HHI and C4-ratio for the basic health insurances have been calculated at the group level. In Figure 3, the HHI and C4-ratio are listed for the period of 2006 - 2015. This reveals that the level of concentration has increased. The C4-ratio increased from 65% in 2006 to 89% last year. The HHI rose from 1,234 points in 2006 to 2,190 points in 2015.²² The increase of the level of concentration in 2006 and 2007 is primarily caused by acquisitions of smaller health insurers by one of the four major health insurers. However, the question of whether this higher level of concentration has also led to less competition in the market is not easily answered, as it depends on many factors and specific circumstances.

Figure 3: C4-ratio (left) and the HHI (right) for on the Dutch market for basic health insurance



Source: Vektis (2015). Adaptation by ACM.

The market shares have not really changed a lot

The C4-ratio and the HHI offer great insight into the level of concentration, but do not offer a good picture of how much the market shares of the largest providers have changed over time. A market in which the market shares of the largest providers change greatly over time, even with a high level of concentration, usually implies a lot of competition.²³ Figure 4 shows the market shares of the four largest health insurance groups for the period of 2006 until 2015. The changes in the market shares in 2007 and 2008, and, by extension, in the level of concentration, can almost entirely be explained by various mergers and acquisitions that took place in that period.²⁴ In addition, the market shares of the four largest groups (Achmea, CZ, VGZ and Menzis) have been very stable since 2008. Adjusted for mergers and acquisitions, the four largest groups combined have only lost 2 percent market share since the introduction of the Zvw. So in terms of market share, the market has not been that dynamic.

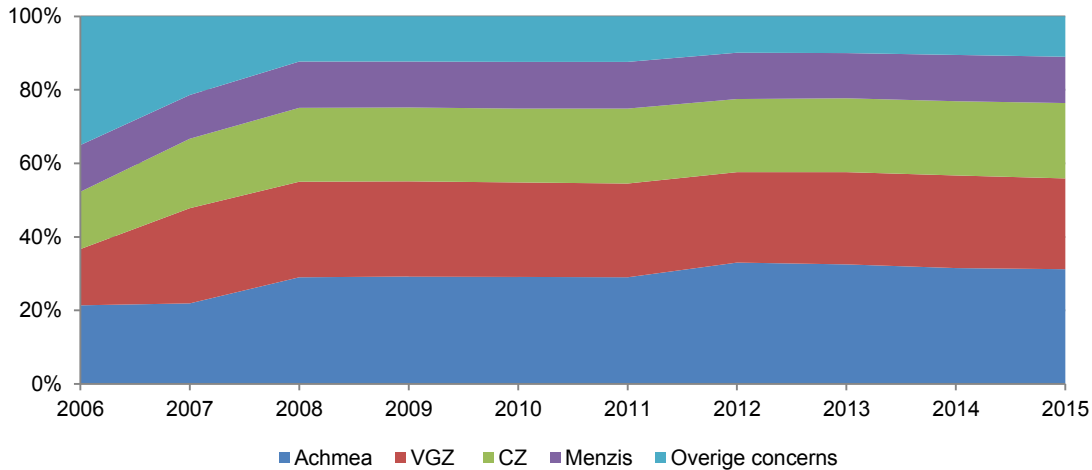
²² The Horizontal Merger Guidelines of the US Department of Justice considers an HHI between 1,500 and 2,500 to be a 'moderately concentrated market.' See <http://www.justice.gov/atr/public/guidelines/hmq-2010.html>.

²³ European Commission - Guidelines on Vertical Restraints (2010/C 130/01), 19 May 2010, section 115.

²⁴ Think for example of the merger between Azivo and Menzis, and the one between Agis and Achmea.



Figure 4: market shares of the four major health insurance groups (2006 – 2015)



Source: Vektis (2015). Adaptation by ACM.

The number of insurance policies in the market has grown dramatically

Product differentiation is a way for competitors to set themselves apart.²⁵ If a provider offers a product that meets the preferences of a group of insured better, they will be willing to pay more for that product. They will only buy a different product if the price difference is large enough to compensate for the fact that they will get a product that meets their preferences to a lesser degree.

Product differentiation thus offers market power to providers vis-à-vis insured who, in terms of their preferences, are closer to the product offerings of those providers. This is not necessarily a bad thing, because the insured also benefit more from a product that meets their preferences better. In this context, however, it is important that it is about objective differences (or at least most of the time), and not about perceived differences. If the latter is the case, then the insured might get confused (this is called *obfuscation*), and not choose the product that is the best match for them.

A combination of laws, regulations, and public pressure has resulted in health insurers being restricted in their options to differentiate. Gupta (2015) has demonstrated that product differentiation with the basic health insurance is mostly feasible on the freedom to choose one's doctor, and on customer service.²⁶ Differentiation on coverage of the basic health insurance is virtually not feasible. However, more opportunities are available for the supplemental health insurance, also in order to eliminate any restrictions in the basic health insurance. Yet, this room seems to be getting smaller and smaller because of public pressure that is put on health insurers.

The nine health insurance groups are active, at least so in the supplemental health-insurance market, with 40 different brands.²⁷ In their marketing efforts, some brands target specific groups of customers such as young people. Other brands set themselves apart by offering the lowest prices or

²⁵ Chamberlin (1933)
²⁶ Gupta (2015), p. 31
²⁷ NZa (2015b), p. 52



complete freedom to choose one's doctor.²⁸ Several brands sometimes offer multiple basic health insurances and supplemental health insurances. The number of different policies for the basic health insurances and supplemental health insurances have slowly increased since 2006. In 2006, there were 45 different basic health insurances and 137 supplemental health insurances on the market.²⁹ Over the past year, these numbers have increased to 71 and 276, respectively.³⁰ The Netherlands Financial Conduct Authority (AFM, 2015) comes to the conclusion that many of the supplemental health insurances on offer do not differ that much from each other in terms of coverage.³¹ The AFM is of the opinion that, as a result thereof, the insured are faced with a range of available products that is unnecessarily cluttered.

All in all, it appears that there *is* product differentiation in the health insurance market. However, based on the AFM's study, among other sources, it is unclear to ACM to what extent such differentiation involves objective differences. In addition, Gupta (2015) notes that laws, regulations and public pressure limit the freedom to differentiate one's products.³² It is therefore questionable whether the current differentiation actually benefits the insured.

Significant barriers to entry exist

In general, markets are more competitive if they have low barriers to entry. With low barriers to entry, positive profits trigger entry immediately. Conversely, barriers to entry may lead to market power.

Gupta (2015) argues that new participants find it difficult and time-consuming to enter the health insurance market.³³ In order to enter the market, they need to apply for a license with the DNB, and they need to have their insurance policies assessed by the NZa. Interviewees of Gupta say that the lack of clear licensing requirements can make such processes laborious. Furthermore, the high risks present in the market do not make market entry attractive. According to the interviewees, these risks are high because of the enormous complexity of the market and because of the public pressure on health insurers. The NZa, too, argues that it is difficult for new health insurers to enter the market.³⁴ According to the NZa, the main barrier is the statutory solvency requirement for health insurers, in combination with a low return on health insurances. Other major barriers to entry are the regulatory burden and the thereto-associate uncertainty, as well as the complex admission process.

So far, not a single new player has entered the market since the introduction of the Zvw. Anno12 made an attempt, but decided in early-2015 to suspend all its activities because it was unable to attract enough customers.³⁵ An initiative was recently launched that, from 2017, should lead to the establishment of a new health insurer called 'Zorgeloos' (which translates to 'carefree' or 'free of

²⁸ This is not necessarily explicit risk selection. In most cases, it is also about directly addressing specific target groups.

²⁹ NZa (2006), p. 12

³⁰ NZa (2015b), p. 49 and 52

³¹ AFM (2015), p. 6

³² Gupta (2015), p. 46-49

³³ Gupta (2015), p. 43

³⁴ NZa (2015b), p. 18.

³⁵ <https://www.anno12.nl/>



concerns' in English). However, an actual entry has, so far, not materialized. This is consistent with the existences of barriers to entry, where it is still unclear to what extent these concern avoidable barriers. After all, various barriers such as solvency and licensing requirements also serve the common interest.

2.4 Conduct of health insurers and consumers

The way health insurers and consumers behave in the market provides information about the nature and level of competition in the health insurance market. In this section, three elements of market conduct will be discussed: the premiums of health insurers, the switching behavior of the insured, and the marketing expenditures of health insurers.

There are significant differences in premiums between basic health insurances

When choosing health insurance, rational consumers base their choices on the price-quality ratio that meets their preferences best. Under effective competition and with homogenous products, this should lead to the elimination of price differences between providers. In the case of differentiated products, under the assumption of effective competition, price differences can be explained by differences in quality, for example, in the service level, freedom to choose one's doctor, and the health insurers' efficiency in procurement. Other price differences may be the result of a certain degree of market power on the part of providers. This market power, in turn, can have different causes such as search and switching costs.

Gupta (2015) shows that, with regard to the basic health insurance, competition is mostly possible on premium, freedom to choose one's doctor and service.³⁶ In that light, Figure 5 shows that the spread in the premiums of health insurers is tremendous; the largest difference in monthly premiums for 2015 is a staggering EUR 31.45, which, on an annual basis, is a difference of over EUR 375. Over the years, this spread has widened. In 2009, the largest difference was EUR 23.35 per month.

These differences in premiums can be explained in part by a difference in quality. All types of basic health insurances were included in the comparison: not just those with complete freedom to choose one's doctor, but also those with restricted freedom, and those with higher deductibles.³⁷ Nevertheless, there is

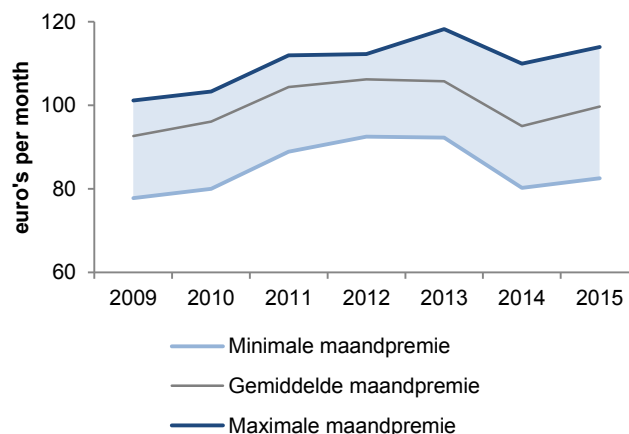


Figure 5: Differences in monthly premiums of the basic health insurance. Source: Home Finance (2009-2015); adaptation by ACM.

³⁶ Gupta (2015), p. 44

³⁷ The cheapest tariff actually belongs to a policy where health care was procured selectively, and the reimbursement options for non-contracted health care are limited. The most expensive tariffs belong to a policy with complete freedom of choice, and also 100% coverage of non-contracted health care. All insurances are based on the statutory deductible.



still a price difference of over EUR 240 between the most expensive fee-for-service plan³⁸ and the cheapest one in 2016. This is a price difference of more than 20 percent.³⁹

The differences in premiums contrast somewhat with what consumers say at what difference in premiums they would switch. In ACM (2015), consumers indicate that, with the same deductible, they would consider it worthwhile to switch health insurances if it saved them on average EUR 120 per year. For some of those with a fee-for-service plan, such a saving should be feasible, but it is unclear as to why these differences in premiums continue to exist.

Search and switching costs can be possible explanations, but search costs are partially mitigated by the presence of price comparison websites. These come in various forms, and may help insured find the right health insurance. However, ACM (2015) reveals that only 8 percent of insured that have switched have taken out their new insurance directly through a price comparison website. That is consistent with the finding that only 37 percent of the insured that have looked around or have actually switched, consider price comparison websites to be trustworthy or very trustworthy. It seems that price comparison websites still have a lot to gain.

A large share of the insured has never switched health insurers, and thus potentially does not benefit from the increase in switching behavior

Consumers play a key role in the promotion of competition. The threat of customers switching to a competitor forces health insurers to improve their products and service on a permanent basis. One parameter of the degree to which health insurers perceive this threat, is the percentage of the insured that switched health insurers every year.⁴⁰

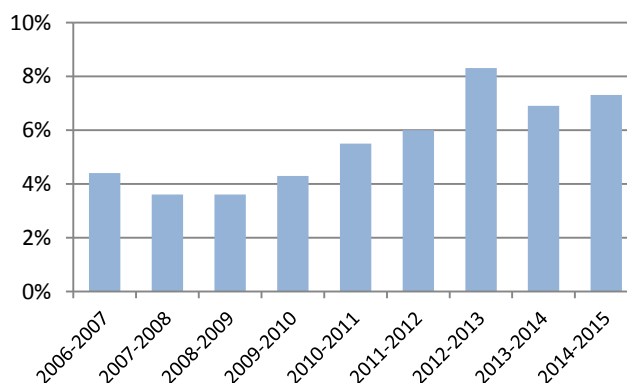


Figure 6: Switching rates for the basic health insurance. Source: Vektis (2015).

Figure 6 shows the percentage of insured that, since 2006, have switched health insurers for the basic health insurance. It shows an increase in the number of switchers. Switches between two insurers within the same group are also included in those percentages. With the available data, it is not possible to look at switches between groups nor at switches between labels (within the same health insurer) or switches between policies

³⁸ With fee-for-service plans (in Dutch: restitutiepolis), insured will get the same reimbursement with every health care provider, and are thus offered more freedom of choice. It can happen that insured must pay the bill themselves first.

³⁹ Source: www.independer.nl on 25 November 2015. The cheapest policy is offered by Ditzo with a monthly premium of EUR 93.85, while the most expensive is offered by De Goudse with a monthly premium of EUR 113.95. The deductible for all insurance policies is the statutory deductible.

⁴⁰ However, a switching percentage in itself does not say anything directly about the level of competition. A low switching percentage could indicate consumer inertia, but it could also point to effective competition where there is no need for the insured to switch.



(within the same label).⁴¹

A switching rate of 7-8 percent in the health insurance market is relatively low compared with energy contracts (14 percent), yet relatively high compared with bank accounts (3 percent) and car insurances (5 percent). However, despite the increased switching rate, a large share of the insured has never switched health insurers. Vektis (2015) shows that 69 percent of the insured has never switched, while 20 percent of the insured has only switched health insurers once since 2006 (see Table 1). This is consistent with ACM (2015), which reveals that 70 percent of the interviewed insured in the switching period 2014-2015 did not consider switching.

Table 1: Switching rates for basic health insurance

Switching rate	Switched between 2006-	Switched between 2006-	Switched between 2006-
	2013	2014	2015
0 times	76%	73%	69%
1 time	18%	19%	20%
2 times	5%	6%	7%
3 times	1%	2%	2%
4 times or more	< 1%	< 1%	1%

Source: Vektis; adaptation by ACM.

Table 1 also reveals that there is a link between past switching behavior and future switching behavior. In late-2014, approximately 5 percent of the insured that, between 2006 and 2014, had never switched before have switched for the first time.⁴² At the same time, approximately 15 percent of the insured that, between 2006 and 2014, had switched once have switched for the second time, and approximately 30 percent of the insured that, between 2006 and 2014, had switched twice have switched for a third time. The insured's willingness to switch thus seems to increase with the number of times they have already switched in the past.

If health insurers are unable to make switchers a better offer than to non-switchers, the insured that do not switch will also benefit from the competitive pressure that the switchers exert. In the last section, it was said that the number of policies in the health insurance market has grown. The NZa has established that the newly-introduced policies often had lower premiums than the average at the time.⁴³ It is possible that these new policies were introduced as a way to discriminate on price

⁴¹ Four levels can be distinguished: groups, insurers (risk carriers), labels, and policies. Groups can have multiple risk carriers, and risk carriers can have multiple labels. Finally, labels can offer multiple policies. For example, the group CZ has four risk carriers (Delta Lloyd Zorgverzekeringen N.V.; OHRA Ziektekostenverzekeringen N.V., OHRA zorgverzekeringen N.V. and OMW CZ Groep Zorgverzekeraar U.A.), and these risk carriers have different labels. For example, OMW CZ Groep Zorgverzekeraar U.A. has the following labels: CZ and Czdirect. And the label CZ has a free-for-service policy and a pre-paid policy (CZ zorg op maat and CZ Zorgkeuzepolis).

⁴² This is an approximation because percentages from different years are not directly comparable, and the percentages have been rounded off, thereby making overestimates and underestimates likely.

⁴³ NZa (2015b), p. 49



between switchers and non-switchers.⁴⁴ This could also explain the earlier mentioned differences in premiums, but more research will have to show whether such is indeed the case.

Over the past few years, health insurers have become more active in their marketing efforts

In order to attract new customers and to retain existing ones, it can be crucial for insurers to invest in customer recruitment and advertising. Health insurers are thus able to make clear what their offerings are, or even to improve the perception of their offerings. Customer recruitment therefore plays a key role in maintaining or increasing one's market share. Gupta (2015) indicates that health insurers' main strategy is to maintain market share.⁴⁵

The theory suggests that the extent and manner of advertising often differs according to the product type. In the economic literature, there are basically three types of products: 'search goods'⁴⁶, 'experience goods'⁴⁷ and 'credence goods.'⁴⁸ Advertising for any of these product types can lead to both increased competition and less competition.⁴⁹ If advertising is predominantly aimed at lowering search costs of the insured, it can have a procompetitive effect. This effect mostly occurs in search goods. However, if the ads are mostly aimed at setting products apart (product differentiation), it can actually have an anticompetitive effect. Firms will then seek to change the perception of their products vis-à-vis those of their competitors, without theirs being an entirely different product, as a result of which the willingness to pay for their products rises. They are thus able to set a higher premium than in a situation of effective competition.

Health insurances are a special product, and share characteristics of all three of those product categories. That is because all policy conditions are available to the insured (search good). Yet there is a tremendous amount of characteristics that make it difficult to get a good overview, and, for example, service can only be assessed properly afterwards (experience good). Finally, the insured are not always fully able to assess the quality of contracted health care, because of the limited availability of quality parameters (credence good).⁵⁰ Such characteristics make it important for health insurers to advertise, since they need to convince the insured that they are better off when taking out insurance with them.

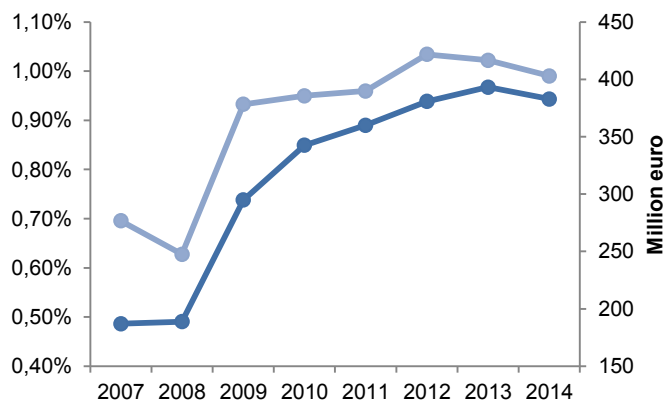


Figure 7: Customer recruitment costs for basic health insurances
Source: DNB Statistic (b), adaptation by ACM.

⁴⁴ This is not about insured with different risk profiles, which would otherwise indicate risk selection.

⁴⁵ Gupta (2015), p. 13

⁴⁶ A search good is one whose features the consumer can ascertain before purchase (Cabral, 2000, p. 223).

⁴⁷ An experience good is one whose features can be ascertained only upon consumption (Cabral, 2000, p. 223).

⁴⁸ A credence good is when quality cannot be determined even after consumption (Cabral, 2000, p. 223).

⁴⁹ For more information, see Cabral (2000) and Dukes (2009).

⁵⁰ Gupta (2015), p. 50



Data of the DNB reveals that the customer recruitment costs of health insurers for the basic health insurance have dramatically increased (see Figure 7). In 2007 and 2008, approximately EUR 180 million was spent on customer recruitment, while in 2014, that number had more than doubled to over EUR 380 million. However, customer recruitment costs cannot be labeled as advertising costs.

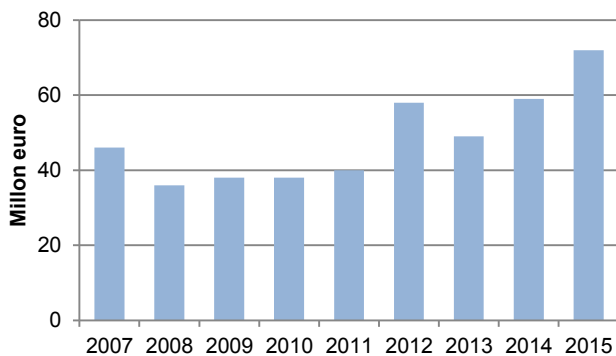


Figure 8: Annual advertising expenditures of all health insurers. Source: BS Health Consultancy (2007-2015).

According to the Dutch Association of Health Insurers (in Dutch: Zorgverzekeraars Nederland), customer recruitment costs include “everything that has to do with recruiting and educating customers”. According to this definition, this also includes all costs associated with taking out new and existing policies.⁵¹ Figure 8 shows that advertising expenditures until 2011 were approximately EUR 40 million, but in 2015, they had risen to EUR 72 million per year.

Health insurers have thus been spending more and more on marketing. Since health insurances are complex products, the question is whether said increase in expenditures has led to an increase in competition. More and more policies for the basic health insurance have entered the market, but Gupta (2015) indicates that objective differentiation on the basic insurance is limited.⁵² Marketing efforts could thus be aimed at changing the perception among the insured without having any basis in changes to the objective characteristics. This could play out negatively for the level of competition, but additional research is needed for this statement.

2.5 Performance of the Dutch health insurance market

A lack of competition gives market participants market power, which means that, to a certain extent, they are able to behave independently from their competitors. Market power can manifest itself in higher prices, reduced quality, and a lack of innovation. Performance parameters can give an indication of the extent to which market power is exerted. For example, high profits may indicate that prices are too high or that there is a lack of competition. There are various parameters with which the performance of providers can be measured. For the health insurance market, information about customer satisfaction, profitability of basic health insurances, and health insurer costs is available.

⁵¹ <http://www.nrcq.nl/2014/11/28/geven-verzekeraars-echt-zoveel-uit-om-jou-te-lokken>

⁵² Gupta (2015), p. 35



In the market for health insurances, performance parameters with regard to the profitability could be less indicative than in other markets. This is because most insurers do not have a profit motive, according to their bylaws. And therefore, they do not necessarily have the incentive to exert any market power in order to increase their profits. A lack of competition is more likely to manifest itself in inefficiently high cost levels, and a lack of innovation.

Consumer satisfaction with health insurers is high but distrust is rising

In a survey conducted by MarketResponse, insured were asked to rate their satisfaction with their current health insurers.⁵³ Of all respondents, 84 percent said they were satisfied or very satisfied. Furthermore, a study by the website Zorgwijzer.nl revealed that there is no link between customer satisfaction with a health insurer and the level of their premium.⁵⁴ The average customer rating of the 15 least expensive insurers is 7.8 (out of 10), and the rating of the 15 most expensive ones is 7.5. The MarketResponse study also found that distrust of health insurers among the insured is rising.⁵⁵ Of all respondents, 40 percent said they had little or very little trust in health insurers keeping the customers' interests in mind, compared with 32 percent in 2014.

Over the past few years, health insurers generated more profit from selling basic health insurances

The Net Combined Ratio (NCR) is a measure that indicates the ratio between, on the one hand, incurred losses and expenses, and, on the other hand, earned premiums.⁵⁶ A value below 100 implies that an insurer's core activities are profitable, and one over 100 indicates loss-making core activities.⁵⁷

Figure 9 shows the NCR for the basic health insurance. It shows that the NCR was above 100 in 2007-2008, which meant that the combined earnings from the basic health insurances were not enough to cover the losses and expenses. After 2008, a downward trend can be observed, where the NCR remains below 100.

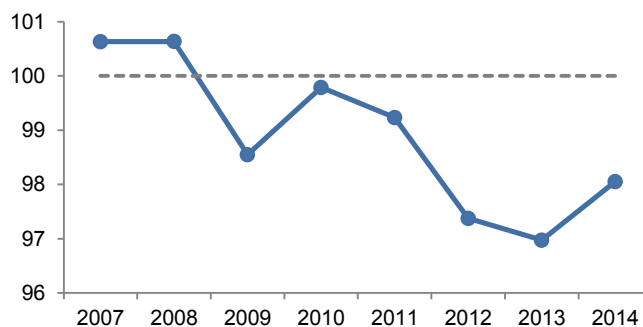


Figure 9: Weighted average NCR for basic health insurances. Source: DNB Statistic (b), adaptation by ACM.

⁵³ MarketResponse (2015), p. 22.

⁵⁴ <http://www.zorgwijzer.nl/zorgverzekering-2016/klanttevredenheid-hoger-bij-goedkopere-zorgverzekeraar>

⁵⁵ MarketResponse (2015), p. 20.

⁵⁶ The NCR shows the insurance-based result: this is the result without investment profits and reinsurances.

⁵⁷ DNB (2008), p. 16. An NCR of over 100 does not mean that an insurer is making a loss. Insurers also have other sources of income besides the revenues from premiums such as the returns on investments and interest earnings. With these sources of income, insurers may still be able to make a profit.

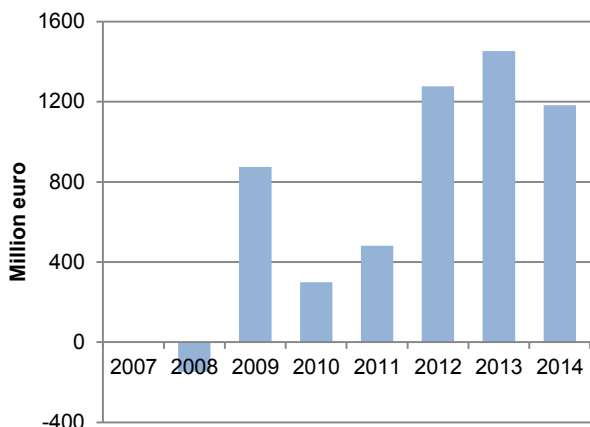


Figure 10: Net result of basic health insurers. Source: DNB Statistic (b).

This trend of the NCR is consistent with the trend of the net results of health insurers from the basic health insurance. The net results are the difference between all revenues and costs. Figure 10 shows the combined net result of health insurers with regard to basic health insurances for the period of 2007 through 2014. This figure reveals that, since 2012, health insurers have generated significantly more profit from basic health insurances than in the previous period. Over the past three years, profits have been between 3 and 4 percent of the premium revenues.

Cost savings do not seem to be the most likely explanation

The increased profitability does not appear to come from cost savings among health insurers. Figure 11 shows that claimed health costs by insured have steadily increased in the period of 2007 through 2014. Health care claims are, by far, the largest cost category for health insurers, but its level cannot be entirely controlled.⁵⁸ Corporate costs (such as staff and buildings) *can* be controlled.⁵⁹ Figure 12 (next page) shows that corporate costs between 2007 until 2010 have decreased by approximately EUR 100 million per year. This is entirely caused by a drop in operating expenses, which may point to increased efficiency among health insurers. On the other hand, customer recruitment costs have increased since 2007. Although corporate costs have dropped by EUR 100 million, this can only explain a fraction of the increase in profits since 2007.

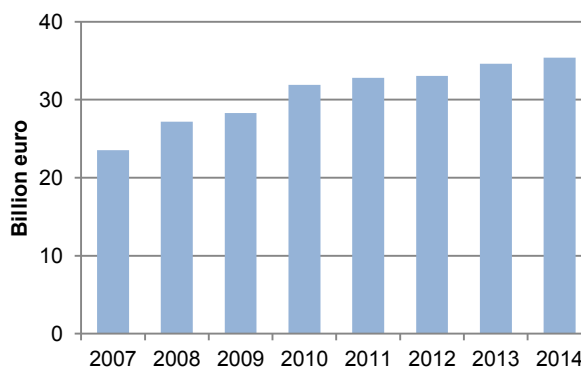


Figure 11: health care claims (basic health insurance). Source: DNB Statistic (a).

⁵⁸ Gupta (2015), p. 34.

⁵⁹ Gupta (2015), p. 27.

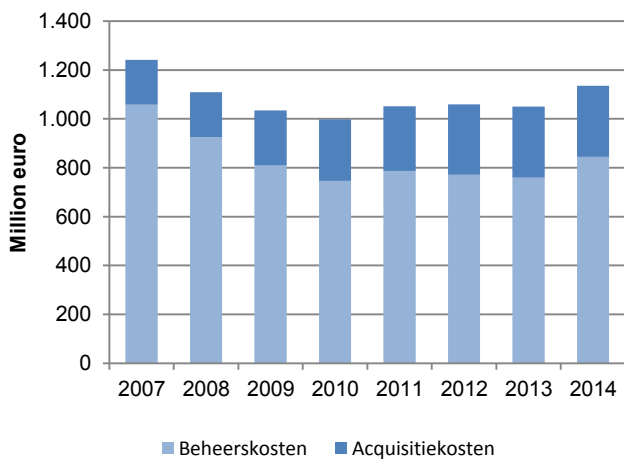


Figure 12: Corporate costs of basic health insurance .
Source: DNB Statistic (b), adaptation by ACM.

2.6 Outcome of the SCP-analysis

In this chapter, a first analysis of the degree of competition in the Dutch health insurance market was made using the SCP-model. The analysis – based on public data - does not indicate that there is effective competition between health insurers.

Based on the analysis, no definitive conclusions can be drawn about the degree of competition in the health insurance market. The relationship between parameters in the SCP-model and competition is not always unambiguous. Furthermore, not all of the possible SCP-parameters have been taken into account in the analysis because of data limitations. Further and more detailed research is needed in order to be able to draw any conclusions with confidence. The purpose of this SCP-analysis is thus to offer a first indication of competition, on the basis of which relevant follow-up studies have been identified in the next chapter.

The NZa (2015) offers several possible explanations for the increase in profits in the past few years.⁶⁰ First, the solvency requirements have been raised.⁶¹ Health insurers subsequently adjusted their premiums accordingly, and have used the profits to raise their financial reserves. Second, the claimed health care costs in that period turned out to be lower than projected, which has led to a windfall. Finally, part of the increase in profits among health insurers can also be explained by better-than-expected returns on investments.⁶²

⁶⁰ NZa (2015a), p. 37.

⁶¹ According to the NZa, the increase in the financial reserves of health insurers was necessary in order to comply with the stricter solvency requirements. First, the solvency requirement in 2010 was raised from 8 percent to 9 percent, and this was further raised in 2012 to 11 percent. Second, health insurers have become more risk-taking after the abolition of most ex-post compensations. Third, health insurers need to hold more equity if they have higher health care expenditures. With the transfer of the Exceptional Medical Expenses Act to the Zvw, health care expenditures have increased dramatically, so health insurers needed to hold more equity. Finally, Solvency II has come into force since 2016, which is stricter than Solvency I, thereby forcing health insurers to hold more equity.

⁶² Minister of Health, Welfare and Sports (2013), p. 2.



3 Research hypotheses and follow-up steps

Based on Gupta's study and ACM's analysis, three separate hypotheses have been drawn up for follow-up studies. These three hypotheses tie in with the most important findings of the study so far. The study will be carried out in cooperation with the NZa. The goal is to come up with detailed recommendations for the three topics below.

Hypothesis 1: Large health insurers have insufficient incentives to differentiate, and thus to attract customers

Gupta (2015) shows that laws and regulations restrict what health insurers can do. Gupta also observes that health insurers are reluctant to differentiate themselves as a result of strong political and public pressure. Despite these restrictions however, there are still opportunities for differentiation, but Gupta argues that these opportunities are not taken full advantage of currently. With regard to health care procurement, for example, Gupta argues that health insurers could separate themselves more by procuring more selectively. One possible explanation is that health insurers are not sufficiently stimulated to differentiate, and thus to gain more market share. Gupta has observed that health insurers primarily aim for consolidating market share, and not necessarily for increasing market share. The relative stability (apart from mergers and acquisitions) of the individual market shares of health insurers is in line with that observation. With a strategy of market share consolidation, health insurers have few incentives to differentiate from their competitors in order to gain market share. As a result thereof, certain products that do have added value for consumers may not get off the ground. That is why ACM and NZa will examine in greater detail as to why health insurers do not take advantage of the opportunities (or why they are not stimulated to do so), and whether this can have harmful effects on consumers.

Hypothesis 2: Unnecessarily high barriers to entry and expansion in the health insurance market limit the competitive pressure exerted by potential entrants and smaller health insurers

As previously discussed under hypothesis 1, the market shares of health insurers show little to no movement. The entry of a new health insurer or having the smaller health insurers grow significantly will not break this stability in market shares either. Anno12 recently tried to enter the Dutch health insurance market, but was forced to abandon this attempt.

Both the NZa (2015) and Gupta (2015) come to the conclusion that new health insurers need to overcome several hurdles if they wish to enter the Dutch health insurance market. It has not been established though that these hurdles are unnecessarily high and avoidable. For example, think of (i) the license application process of the DNB, (ii) the complexity of and high risks in the market, (iii) the complexity of and uncertainty in laws and regulations, and (iv) the solvency requirements. These last two factors could also curb the growth of health insurers (small and large) next to curbing the entry of potential competitors. After all, the solvency requirements mandate that health insurers have enough equity for each new customer. Health insurers are thus restricted in their growth potential. Similarly to ACM's previous conclusion in the retail banking sector, this could lead to capacity restrictions, which may affect competition adversely.



Hypothesis 3: Limited transparency and unnecessary complexity of the product range limit the competitive pressure exerted by consumers on health insurers

Every year, consumers are able to switch their provider of health insurance. Between mid-November and the end of December, consumers are bombarded with various offers on regular media channels, price-comparison websites, through collective organizations, and in target-group advertising. Health insurers in 2014 spent over EUR 380 million on customer-recruitment, of which EUR 72 million was spent on advertising. As a result thereof, next to other reasons, approximately 7 percent of consumers switch health insurer every year. However, since 2006, 69 percent of all consumers have never switched, despite differences in prices that could be as wide as EUR 240 per year (in fee-for-service plans). In that context, it is possible that, through different labels within a single insurance group, there is price discrimination between switching and non-switching consumers. Those consumers that have never switched before therefore benefit to a lesser extent from the competitive pressure that is exerted by switching consumers.

In 2015, there were 71 different basic health insurance policies, and 276 supplemental insurance policies available to consumers, apart from the collective offers. Based on these numbers, consumers seem to have sufficient choices. However, the question is whether consumers are capable of choosing the health insurance policy that meets their needs best. According to AFM (2015), several supplemental insurances actually hardly differ from one another, in spite of what the health insurers' marketing efforts want consumers to believe. The differences between health insurers may thus be primarily based on non-objective characteristics, which stifles competition between health insurers.

Follow-up steps

Bases on Gupta (2015) and ACM's study so far, the three hypotheses have been drawn up. This year, ACM and the NZa will assess these hypotheses further. Any comments from market participants on these hypotheses are welcome. In the rest of this study, ACM and the NZa will also actively reach out to market participants, and ask them for relevant information. The main goal is to come up with concrete recommendations that help promote competition in the health insurance market, without harming other public interests.



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5 List of abbreviations

ACM	Netherlands Authority for Consumers and Markets (<i>Autoriteit Consument en Markt</i>)
AFM	Netherlands Financial Conduct Authority (<i>Autoriteit Financiële Markten</i>)
DNB	Dutch Central Bank (<i>de Nederlandsche Bank</i>)
NCR	Net Combined Ratio
NZa	Netherlands Healthcare Authority (<i>Nederlandse Zorgautoriteit</i>)
Zvw	Dutch Health Insurance Act (<i>Zorgverzekeringswet</i>)